GACS
GASTROENTEROLOGY ASSOCIATES
COLORADO SPRINGS

Pikes Peak Endoscopy Center
PIKES PEAK ENDOSCOPY CENTER

1699 Medical Center Point, Colorado Springs, Colorado, 80907

Thank you for choosing Pikes Peak Endoscopy Center for your procedure.

Please arrive 30 minutes prior to your scheduled appointment time.

You should have received the following paperwork:

- ☐ Procedure Instructions
- ☐ Sample Procedure Consent
- ☐ Patient Bill of Rights
- ☐ Financial Policy
- ☐ Patient Information Sheet
- ☐ Health Questionnaire with Medication Sheet
- ☐ Advanced Directives
- ☐ Acknowledgement Form

Please bring the following to your procedure:

- ☐ Paperwork:

Patient Information Sheet ● Health Questionnaire ● Advanced Directives ● Acknowledgment Form

- ☐Photo Identification/Current Insurance Card
- ☐Inhaler or Insulin (If applicable)

Please review the information you have received 10 days prior to procedure. This packet contains information that is important in the days leading up to your procedure. If information in this packet is not reviewed, you may miss essential information.

Location:

1699 Medical Center Point, 1st Floor
Phone: (719) 632-7101 Fax: (719) 632-4468
www.GACSonline.com

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Upper Endoscopy/EGD

Procedure Instructions

Please Read All Enclosed Information & Follow Instructions Carefully	
Detailed step-by-step instructions follow below this table:	
1 week prior to procedure	Speak to your primary care physician about medications such as: • **Coumadin (Warfarin), Plavix, Ticlid, Pradaxa, Eliquis, or any other Blood Thinners***** • You may need to discontinue these medications up to 1 week prior to your procedure. • You **may** continue to take a daily aspirin.
1 day prior to procedure	• Normal Diet • Continue all daily medications unless otherwise directed by your primary care provider.
Day of your procedure	• **NO** solid food 8 hours prior to your procedure. **Clear Liquids Only.** • **NOTHING** by mouth 4 hours prior to the procedure. • Please take daily medications as usual (unless instructed otherwise). Take these at least 4 hours prior to the procedure. • If you use an inhaler, please bring this to your appointment. • NO GUM, HARD CANDY, COUGH DROPS or CHEWING TOBACCO. • DO NOT SMOKE MARIJUANA, CIGARETTES, PIPES, VAPE PENS or E-CIGARETTES. Please bring your ID and current insurance card. **You must be accompanied by or have arranged an adult to drive you home. You may not drive or go home by TAXI/UBER/LYFT/BUS ETC.**

Please contact our office if you have had a respiratory illness in the past 6 weeks or are current experiencing respiratory symptoms.

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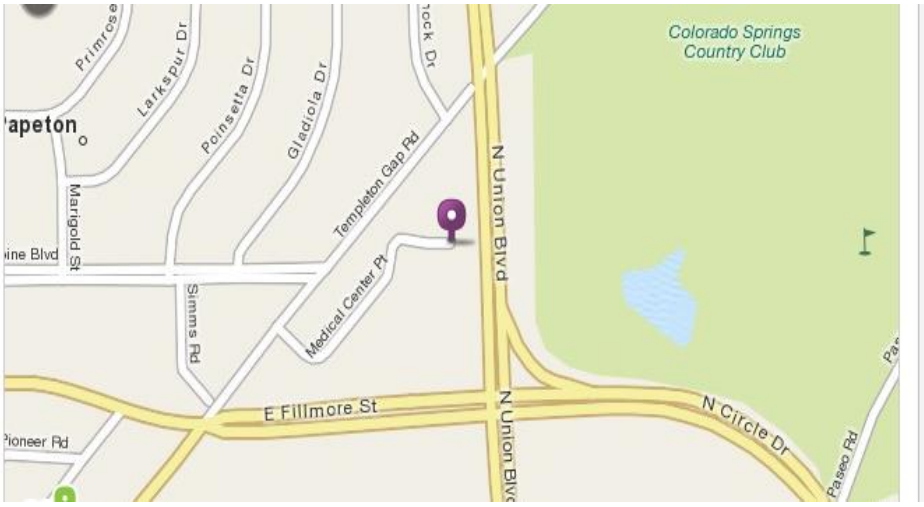

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AUTHORIZATION FOR EGD

1. PROCEDURE AND ALTERNATIVES: I, _____, (PATIENT OR GUARDIAN) AUTHORIZE DR. _____ TO PERFORM THE PROCEDURE: ESOPHAGOGASTRODUODENOSCOPY (EGD) EXAMINATION OF THE LINING OF THE ESOPHAGUS, STOMACH, AND DUODENUM WITH A FLEXIBLE VIDEO SCOPE, AND IF NECESSARY REMOVE POLYPS AND/OR SMALL PIECES OF TISSUE (BIOPSIES) FOR DIAGNOSIS; AND DILATION (STRETCHING) OF THE ESOPHAGUS IF INDICATED.

I UNDERSTAND THE REASON FOR THE PROCEDURE IS:_____

ALTERNATIVES INCLUDE: UPPER GI X-RAYS, SURGERY_____

2. RISKS: THIS AUTHORIZATION IS GIVEN WITH THE UNDERSTANDING THAT ANY PROCEDURE INVOLVES SOME RISKS AND HAZARDS. THE MORE COMMON RISKS INCLUDE: INFECTION, BLEEDING, ABDOMINAL PAIN, PERFORATION OF ESOPHAGUS, STOMACH OR DUODENUM, NERVE INJURY, BLOOD CLOTS, HEART ATTACK, ALLERGIC REACTIONS, AND PNEUMONIA. THESE RISKS CAN BE SERIOUS AND MAY REQUIRE SURGERY OR POSSIBLE BE FATAL. ESTIMATED PERFORATION RATE IS 1:2,000, WHICH USUALLY REQUIRES SURGERY.

3. ADDITIONAL PROCEDURES: IF MY PHYSICIAN DISCOVERS A DIFFERENT, UNSUSPECTED CONDITION AT THE TIME OF THE PROCEDURE, I AUTHORIZE HIM TO PERFORM SUCH TREATMENT, AS HE DEEMS NECESSARY.

4. ANESTHESIA: I UNDERSTAND THAT, SUBJECT TO MEDICAL CRITERIA AND AVAILABILITY, I MAY CHOOSE TO RECEIVE ANESTHESIA THROUGH EITHER IV CONSCIOUS SEDATION/MIDAZOLAM (VERSED)/FENTANYL OR GENERAL ANESTHESIA/PROPOFOL. MY PHYSICIAN HAS DISCUSSED THESE CHOICES WITH ME AND ADDITIONAL INFORMATION IS INCLUDED ON THE ANESTHESIA INFORMATION SHEET, WHICH HAS BEEN PROVIDED TO ME FOR REVIEW. I UNDERSTAND THAT EITHER IV CONSCIOUS SEDATION/MIDAZOLAM/FENTANYL OR GENERAL ANESTHESIA/PROPOFOL MAY CARRY RISKS, INCLUDING BUT NOT LIMITED TO, DENTAL INJURIES, PNEUMONIA, HEART ATTACK, OR OTHER ADVERSE REACTIONS INCLUDING DEATH.

5. LIMITATIONS OF EGD: EGD IS CURRENTLY THE BEST TEST AVAILABLE TO EXAMINE THE ESOPHAGUS, STOMACH AND DUODENUM. IT DOES HAVE LIMITATIONS AND MAY NOT PROVIDE MY PHYSICIAN WITH DEFINITIVE INFORMATION ABOUT MY CONDITION. THE TEST MAY BE LIMITED BY TECHNICAL FACTORS DURING THE EXAMINATION OR BY CONDITIONS THAT MAY DEVELOP IN THE ESOPHAGUS, STOMACH OR DUODENUM AFTER THE TEST HAS BEEN COMPLETED (BUT UNRELATED TO THE TEST). THE PATIENT SHOULD ALERT THEIR PHYSICIAN ABOUT ANY CHANGE IN OR NEW SYMPTOMS THAT MAY DEVELOP. THEREFORE, I UNDERSTAND THAT NO GUARANTEE OR ASSURANCE HAS BEEN MADE AS TO THE RESULTS OF THE PROCEDURE AND IT MAY NOT DIAGNOSE, CURE OR TREAT MY CONDITION.

6. I UNDERSTAND THAT NO GUARANTEE OR ASSURANCE HAS BEEN MADE AS TO THE RESULTS FOR THE PROCEDURE AND THAT IT MAY NOT CURE THE CONDITION.

7. PATIENT'S CONSENT: I HAVE READ AND FULLY UNDERSTAND THIS CONSENT FORM, AND UNDERSTAND I SHOULD NOT SIGN THIS FORM IF ALL ITEMS, INCLUDING MY QUESTIONS, HAVE NOT BEEN EXPLAINED OR ANSWERED TO MY SATISFACTION OR IF I DO NOT UNDERSTAND ANY OF THE TERMS OR WORDS IN THIS CONSENT FORM.

IF YOU HAVE ANY QUESTIONS AS TO THE RISKS OR HAZARDS OF THE PROPOSED PROCEDURE OR TREATMENT, OR ANY QUESTIONS CONCERNING THE PROPOSED PROCEDURE OR TREATMENT, ASK YOUR PHYSCIAN BEFORE SIGNING THIS CONSENT FORM.

This is an example of our consent for procedure for informational purposes. You will sign this sheet in the presence of your physician after your questions and concerns have been answered.

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Statement of Patient Bill of Rights

BELIEVING IT IS ESSENTIAL THAT PATIENTS ARE RESPECTED AND SUPPORTED

In recognition of the responsibility of this facility in the rendering of patient care, these rights are affirmed in the policies and procedures of ***Pikes Peak Endoscopy Center.***

Patients have the Right:

To receive services without regard to race, color, age, sex, sexual orientation, religion, marital status, handicap, national origin or sponsor.

To be provided reasonable physical access.

To be provided a secure environment for self and property.

To be provided with appropriate privacy.

To be treated with respect, consideration and dignity.

To expect that all disclosures and records are treated confidentially, except when required by law, and to be given the opportunity to approve or refuse their release.

To be provided, to the degree known, complete information concerning their diagnosis, treatment and prognosis. When it is medically inadvisable to give such information to a patient, the information is provided to a person designated by the patient to be a legally authorized person.

To be given opportunity to participate in decisions involving their health care, except when participation is contraindicated for medical reasons.

To receive from his/her physician information necessary to give informed consent prior to the start of any procedure and/or treatment, except in emergencies. Such information for informed consent should include the specific procedure and/or treatment, significant medical risks involved , and the probable duration of incapacitation. Where significant alternatives for medical care or treatment exist, or when the patient requests information concerning medical alternatives, the patient has the right to such information and the consequences of not complying with therapy. The patient has the right to know the name of the person responsible for the procedures and/or treatment.

To be informed, when appropriate, of treatment policy for an emancipated minor not accompanied by an adult.

To refuse treatment and be informed of consequences of refusing treatment or not complying with therapy.

To be informed as to:

- Expected conduct and responsibilities as a patient
- Services available from the facility
- Provisions for after-hours and emergency care'
- Fees for services
- Payment policies
- Right to refuse participation in investigational studies or clinical trials
- Methods for expressing grievance and suggestions to the facility
- Disclosure of ownership
- Procedure for reporting public health concerns to the appropriate authorities

To be informed of their rights to change primary or specialty physicians if other qualified physicians are available.

To be free from all forms of abuse or harassment.

To file a grievance against the center by contacting the administrator by mail or phone. If the outcome is not satisfactory a patient can contact the state licensing board through their website http://www.dora.state.co.us/medical or file a complaint by emailing hfintake@cdphe.state.co.us. You may also call 1-800-886-7689 ext 2904. If you have Medicare you may visit the Medicare website at http://www.medicare.gov/ombudsman/resources.asp.

To exercise his or her rights without being subjected to discrimination or reprisal

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Financial Policy

IMPORTANT – PLEASE READ

Patients are responsible for payment of all services provided by Gastroenterology Associated of Colorado Springs, LLP (GACS), Pikes Peak Endoscopy and Surgery Center, LLC, and Anesthesia of the Rocky Mountains, LLC.

The Financial Policy and Disclosure is to help us provide the most efficient and reasonable health care services. Therefore, it is necessary for us to have a Financial Policy and Disclosure stating our requirements for payment for services provided to patients. The center is fully certified Medicare approved and licensed by the state of Colorado. Anesthesia services are provided by Anesthesia of the Rocky Mountains which is owned by the physicians of GACS.

Fees and Cancelation: Please cancel/reschedule before the times listed below or fees may apply.

Office Visit:	**24 Hours**	**$50.00**
Procedure (EGD/Colonoscopy):	**24 Hours**	**$100.00**
Returned Check Fee:	**$50.00**	

LATE PAYMENTS: Accounts 30 days or more past due will begin accruing finance charges.

APPOINTMENTS:

- Please arrive at least 30 minutes prior to your appointment allow time to complete paperwork, update records and prepare you for procedures (if applicable)

SELF-PAY PATIENTS:

- Payment for services is due in full at the time of service or payment arrangements need to be made with our billing department prior to the service.
  - ❖ Acceptable methods of payment: VISA, MasterCard, cash, checks and money orders.

INSURED PATIENTS:

- **Please check with your coverage provider regarding coverage.**
- We will file your primary and supplemental insurance for you as a courtesy to you under surgical provisions. However, you need to provide us with complete and accurate insurance information as well as a copy of your insurance card(s).
- Although we participate with most insurance companies, it is your responsibility to make sure we are a participating provider with your plan.
- Payment is due at time of service. Deductibles and co-insurance amounts applied to the claim will be your responsibility and a deposit for these amounts will be due at the time of service.
- Services not covered or deemed not medically necessary by your plan will be billed to you and are your responsibility. You will be responsible for any remaining balance on your account once your insurance has processed our claim.

REFERRALS:

- Please check with your insurance provider to see if a referral is required
- If referral is required: It is your responsibility to request and obtain a referral from your primary care provider.
- If a referral is not in place, you will be responsible for payment or your appointment may be rescheduled until a referral is received from your primary care physician
- Procedure prior authorization (if applicable) will be obtained prior to procedure on your behalf. You will be notified of your financial responsibility prior to the procedure if prior authorization is not approved. Please be aware that pre-authorization by your insurance company does not guarantee insurance payment for services.

COLLECTION AGENCY: We refer all unpaid accounts over 90 days past due to a third-party collection agency unless the account has been approved for payment arrangements.

CUSTOMER SERVICE: If you wish to discuss your account and/or set up financial arrangements, please contact our billing department at (719) 477-0755.

ADDITIONAL FEES: The procedure for which you are scheduled generates the following fees that will be billed separately: (1) a professional fee for the physician's services. (2) a facility fee for use of the surgery facility. (3) Pathology services (if applicable) and, (4) a professional fee for anesthesia services.

OVERPAYMENTS: We will not typically refund credit balances less than $10.00 due to the cost of processing these low amounts. These credits are applied to future due amounts or can be refunded at the request of the patient and picked up at one of our local offices. Refunds that are not claimed or returned to us are reported to the state of Colorado annually.

ADDITIONAL INFORMATION: By supplying my home phone number, mobile phone number, email address, and any other personal contact information, I authorize my health care provider to employ a third-party automated outreach and messaging system to use my personal information, the name of my care provider, and other limited information, for the purpose of notifying me of an unpaid balance. I also authorize my healthcare provider to disclose to third parties, who may intercept these messages, limited protected health information regarding healthcare events, unpaid balances and to leave a reminder message on my mobile phone, email and voice mail or answering system

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PATIENT INFORMATION SHEET

Please complete and return

Patient Name:_____SSN#_____

Address:_____
STREET CITY STATE ZIPCODE

Date of Birth:_____ **Gender**(please circle): M F **Status:** Married Single Divorced Widowed

Please check the box if you would prefer us **NOT** to contact you at the below numbers/address

☐ Home Phone # : _____
☐ Work Phone # : _____
☐ Cell Phone # : _____ ☐ **Email Address**: _____

Emergency Contact (Name/Telephone #):_____
Primary Care Physician (First/Last Name):_____
Referring Physician (First/Last Name):_____

I authorize the physician or anyone acting on his/her behalf to leave pertinent messages for me regarding my medical condition on my answering machine and/or voice mail.

(Please circle one) Yes No

Financially Responsible Party *(If Different From Patient)*

Last Name:_____First Name:_____MI:_____

Street Address:_____City:_____ State:_____

Home Phone:_____ Work Phone:_____ SS#_____

Date of Birth: _____ Relationship to Patient_____ Gender: M F

Insurance Information *(Must be completely filled out)*

Primary Insurance Co Name:	**Secondary Insurance Co Name:**
Insurance Co Address:	Insurance Co Address:
Patient's Insurance Policy #:	Patient's Insurance Policy #:
Patient's Group #:	Patient's Group #:
Insured's Name:	**Insured's Name:**
Insured's SS#:	**Insured's SS#:**
Insured's Date of Birth:	**Insured's Date of Birth:**
Insured's Employer Name:	Insured's Employer Name:
Insured's Employer Phone #:	Insured's Employer Phone #:
Patient's Relationship to Insured:	Patient's Relationship to Insured:

The signature below is my authorization for the release of information necessary to my primary care, referring physician's office, and/or consultants if needed, and as necessary to process insurance claims, obtain pre-authorizations or pre-certifications for treatment, process insurance applications, and obtain prescriptions. I hereby authorize payment directly to the physician/facility for all insurance benefits otherwise payable to me.

Signature:_____ Today's Date:_____

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Patient Health Questionnaire

Please Print and Return

Today's Date:_____

Patient Name: _____ **Date of Birth**:_____

Referring Physician:_____

Physicians who will need report:_____

Reason for today's visit:_____		
Please check any of the following symptoms that you are experiencing:		
☐ Change in Bowel Habits	☐ Weight Loss	☐ Blood in Stool/Rectal Bleeding
☐ Diarrhea	☐ Difficulty Swallowing	☐ Anemia
☐ Abdominal Pain	☐ Heartburn	☐ Nausea/Vomiting
☐Abnormal X-ray/CT Scan	When?	
☐ ER Visit	When?	Diagnosis:

Personal History-: Have you had the Following?	
Colon Polyps	☐Yes ☐ No
Cancer	☐Yes ☐ No Type:_____

Family History:		**Age at Diagnosis?**
☐ Colon Polyps	Relationship:	
☐ Colon Cancer	Relationship	
☐ Rectal Cancer	Relationship:	
☐ Esophageal Cancer	Relationship:	
☐ Barrett's Esophagus	Relationship:	

Medical Conditions:			
☐ Asthma	☐ Irregular Heartbeat	☐ HIV	☐ Kidney Disease
☐ COPD (Emphysema)	☐ Pacemaker/Defib	☐ Hepatitis B/C	☐ Diabetes Type 2
☐ Sleep Apnea	☐ Heart Failure	☐ Clostridium Difficile	☐ Diabetes Type 1
☐ Recent Infection	☐ Heart Attack	☐ Cirrhosis	☐ Anxiety/PTSD

Other:_____

Surgical History- Please List Surgical History with Approximate Dates:

_____

_____

_____

_____

_____

_____

Social History	**What?**	**How Often:**	**Quit? List Date:**
☐ Tobacco:			
☐ Marijuana:			
☐ Alcohol:			

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Patient Health Questionnaire Cont.

Preferred Pharmacy:_____

Location of Pharmacy:_____

Allergies:

☐No Known allergies

1._____ Reaction:_____
2._____ Reaction:_____
3._____ Reaction:_____
4._____ Reaction:_____
5._____ Reaction:_____
6._____ Reaction:_____

Please list additional allergies at the bottom of this page.

Medication Name	Dose:	Last Taken:

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Advanced Directives

Please Print and Return

Pikes Peak Endoscopy and Surgery Center, LLC requires the following notice be signed by each patient prior to the scheduled procedure in order to be in compliance with the Self-Determination Act (PSDA) and State laws and rules regarding advance directives. Advance directives are statements that indicate the type of medical treatment wanted or not wanted in the event an individual is unable to make those determinations and who is authorized to make those decisions. The advance directives are witnessed prior to serious illness or injury.

In the ambulatory care setting, if a patient should suffer a cardiac or respiratory arrest or other life-threatening situations, the signed consent implies consent for resuscitation and transfer to a higher level of care. Therefore, in accordance with federal and state law, this facility (PPESC) is notifying you it will NOT honor previously signed advanced directives (aka: DNR or Do Not Resuscitate Order) for any patient, however, if you have executed an advance directive in the past you may bring it with you and we will scan it into our system.

If you have questions, please call (719) 632-7101 and follow the appropriate prompts to speak to a scheduler.

I have read and fully understand the information presented in this release form.

DO NOT SIGN UNLESS YOU HAVE READ AND THOROUGHLY UNDERSTAND THIS FORM

_____ _____
Signature Date

_____
Printed Name

_____ _____
Signature of Patient Representative Date

_____ _____
Printed Name of Patient Representative Relationship

_____ _____
Witness Signature Date

.

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Acknowledgement Form

Please Print and Return

I acknowledge full financial responsibility for services provided to me. I understand that I am responsible for prompt payment of any portion of the charges not covered by insurance, including co-payments, coinsurance and deductibles. I understand that under provisions of HIPAA (The Health Insurance Portability and Accountability Act of 1996), my insurance company and/or employer group plan administrator may be notified if I fail to fulfill my financial obligations for the payment of deductibles and coinsurance. I agree to all reasonable attorney fees and collection costs in the event I default on payment of my charges. I also consent that direct payment of authorized insurance benefits are paid on my behalf to Gastroenterology Associates of Colorado Springs, Pikes Peak Endoscopy Center, and/or Anesthesia of the Rocky Mountains.

I acknowledge receipt and review of the Patient Bill of Rights and HIPPA disclosure. I understand the information that has been presented.

By signing below, I acknowledge that I have received, read, understand, and agree to the terms of this Financial Policy and Patient Agreement, Patient Bill of Rights, and HIPPA disclosure. In addition, by signing below, I represent and warrant that I have authority to enter into this Agreement

---

Please Sign Below

_____ _____

Signature Date

_____

Printed Name

_____ _____

Signature of Patient Representative Date

_____ _____

Printed Name of Patient Representative Relationship